

reviews

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A Long Walk Home

Rachel Clark with Naomi Jefferies,
John Hasler and David Pendleton



Radcliffe Medical Press,
£19.95, pp 142
ISBN 1 85775 906 0

Rating: ★★★★★

Interviewing prospective medical students is a privilege. Most hopeful applicants appear to be caring, empathic young people with a genuine concern for others. All medical schools now teach communication skills as an integrated part of the curriculum. So why do so many people feel hurt and let down by doctors' attitudes when they are faced with the most frightening and worst possible time of their

lives—the diagnosis and ensuing sequelae of a terminal illness?

A few days before being asked to review this book I had listened with anger and disbelief at the pain and frustration voiced by a neighbour. His wife, who had been admitted for urgent but fairly routine surgery, was told without any warning in the middle of a busy ward round, "Of course it was cancer ... what did you expect?" These words are eerily echoed in Rachel Clark's book, which movingly and truthfully chronicles her dealings with medical, nursing, and allied professionals in Sydney and then in London during and after the diagnosis of a rare head and neck cancer.

Rachel and later her twin, Naomi, take the reader through the experiences of being a patient, being given, and sometimes seeking, a bewildering array of options and conflicting information, and yet not knowing which way to turn or what to do with the answers. The loss of important scans, cancelling of vital appointments, and the general confusion of where to go next are themes that will be familiar to us all as professionals and users of the health service. When cancer

is diagnosed patients are linked into several different professionals and agencies—multidisciplinary working is essential in cancer and palliative care. But somebody needs to conduct the orchestra. In the United Kingdom the obvious person to carry out this role is the general practitioner, yet GPs are often unintentionally sidelined. Many GPs may feel they have little to offer, especially when things change so quickly and letters arrive so slowly. Patients consumed by hospital appointments may not see the relevance or have the energy to make yet another appointment with the GP.

A Long Walk Home is an extremely well written book that may make many of us squirm with discomfort. More importantly, it may make us stop and consider how we would want our loved ones or indeed ourselves to be treated when faced with any serious illness.

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Bacchic Medicine: Wine and Alcohol Therapies from Napoleon to the French Paradox

Harry W Paul



Editions Rodopi BV,
€30/\$28/£28.70, pp 341
ISBN 90 420 1111 4
ISSN 0045-7183

Rating: ★★

Wine, said Louis Pasteur, is the most healthful and the most hygienic of all beverages. Since antiquity, wine was believed to stimulate the appetite, aid digestion, and act as a general energiser in debility, and was prescribed for practically every complaint. In *Bacchic Medi-*

cine Harry W Paul, professor of history at the university of Florida, charts in scholarly, though somewhat confusing and repetitive detail, the rise and fall of the French love affair with *vinotherapie*.

This affair began in earnest at the beginning of the 19th century, when scientific theories from Britain provided evidence that wine, the gift of Bacchus, could indeed be a miracle cure. Quality and age were all important, and wines from different vineyards had to be matched to the temperament of the particular patient. Thus physicians required the skills of masters of wine as well as of medicine, and medical societies debated the respective virtues of reds and whites and the merits of burgundies, champagnes, and the like. Recommended dosage, such as three to six goblets with meals or one to three glasses of champagne five times a day, would now be considered somewhat excessive.

By the end of the century "the mighty remedy had fallen rapidly from its perch of therapeutic domination," as medicinal drugs took over and society was alarmed by the increasing threat of alcoholism. Experts argued that wine was different from other alcohols: it contained useful chemicals and did not cause diseases like cirrhosis.

By the 20th century the industry was in the doldrums: a market flooded with medio-

cre wines, vineyards ravaged by phylloxera, and a treacherous medical profession emphasising the rising tide of alcoholism. The doctors of Bordeaux and the Société de Médecine de Paris hit back by reporting that up to 60 cl a day (about 7 units) of light, natural wine cut with water was good for health and contained easily assimilable chemicals that could fight disease. Alcoholism resulted from "industrial" alcohols such as beer and spirits, and not from grape alcohol.

The wine glut continued after the first world war, and prohibition in the United States didn't help, but modern physico-chemical theories demonstrated that the content of wine was comparable to that of a living cell and nutritional value similar to that of human breast milk. Additional selling points, such as the presence of vitamins, and even mild radioactivity, failed to put wine back on the therapeutic agenda. A last gasp of recent times has been "the French paradox," mightily promoted by the media, that the French have low levels of coronary artery disease in spite of a high fat diet. Red wine especially contains antioxidants, cholesterol lowering agents, and clot-busting substances that might be protective. But then if wine is that good, why do only 28% of French people drink it regularly?

Alex Paton *retired consultant physician, Oxfordshire*

Items reviewed are rated on a 4 star scale (4=excellent)

Making Babies: Is There a Right to Have Children

Mary Warnock



Oxford University Press,
£9.99, pp 120
ISBN 0 19 280334 4

Rating: ★★★★★

Would you care to spend a day or two—or perhaps some short periods of free time in your hectic and stressful schedule—in the company of a philosopher? While that prospect might not immediately sound enticing, it would and should make a difference if you knew that the philosopher in question was Mary Warnock.

Since she chaired the Committee on Human Fertilisation and Embryology, from 1982 to 1984, Mary Warnock has been the most influential voice in the United Kingdom on these matters. The committee's recommendations formed the basis for the Human Fertilisation and Embryology Act of 1990, which created the Human Fertilisation and Embryology Authority (HFEA), a regulatory body responsible for embryo research and assisted conception using donor gametes.

More recently, as the unexpectedly contentious debate on therapeutic cloning and stem cell research unfolded in the House of Lords in January 2001, Lady Warnock's vote was eagerly sought by both sides. And her speech was listened to with rapt attention. I know; I was there.

There has been a bit of sniping and rather a lot of shock as some of Lady Warnock's conclusions in *Making Babies* have found their way into the broadsheets ahead of the book's publication. An article in the *Guardian* sternly noted that she had changed her mind on several key issues. These were preserving the anonymity of sperm donors (perhaps it's not a good idea); surrogate parenting (perhaps it wouldn't be so bad after all); and, most stunningly of all, on reproductive cloning (cloning as the remedy of last resort for male infertility may well be morally acceptable, if it is ever proved possible and completely safe).

I tend to agree with her more recent conclusions on these three issues. But even if I didn't, I could not fail to find virtue in someone whose mind is receptive to growth and self-questioning, and willing to take note of societal transformations and new evidence.

Readers in Britain will come to this book with an acute sense of its relevance. Hardly a week goes by in which some new controversy, moral dilemma, or heartbreaking case is not just in the news but is big news. The case of the IVF (in vitro fertilisation) mix-up—uncovered when a white woman gave birth to black twins—was followed in quick succession by the HFEA's denial of a

licence request for tissue typing for the purpose of producing a baby whose cord blood could save the life of a 3 year old child with Diamond Blackfan syndrome.

Then there was the case of the young woman who, having been diagnosed with ovarian cancer, had produced embryos and had them stored, only to learn that her former partner was withdrawing his consent not only to their use, but also to their storage. Under the law, they had to be destroyed.

This book could not be more timely. People pay attention to what Mary Warnock thinks because of the way that she thinks. In *Making Babies*, the narrative "I" is very much in evidence. She is an informative, analytically rigorous, yet always companionable and deeply humane guide through the moral thicket that is early 21st century assisted reproduction. This is a small book, just over 100 pages in length, with about two dozen chapters. It can be read straight through or as time permits.

Arlene Judith Klotzko lawyer, bioethicist, and adviser on science and society to the MRC Clinical Sciences Centre



WEBSITE
OF THE
WEEK

Hypertext Academics like to shore up their publications with footnotes, tables, and long lists of references. But editors worry that general readers find this scholarly paraphernalia more of a nuisance than a help, cluttering the page and obscuring the line of argument. One solution for journals that have an electronic version, such as the *BMJ*, is to put the full version—including these extras—on the web.

Chris McManus, who won a Wellcome Trust prize designed to enable a professional scientist to write a popular science book, has done something similar for *Right Hand, Left Hand: The Origins of Asymmetry in Brains, Bodies, Atoms and Cultures* (Weidenfeld & Nicolson, 2002). Believing that this sort of thing should be scholarly but not academic, he decided not to include the footnotes that he wrote during the book's preparation. Instead, he created an electronic equivalent, hypertexts, which can be viewed at www.righthandlefthand.com. As well as the notes themselves, the html version has pop-ups and links to other sites—footnotes to the footnotes, if you like.

Hypertext theorists (see <http://alpha.qmw.ac.uk/~english/cbl/project/fivestanding/hype/hyper-text.htm>) contrast the inflexible linearity of conventional text with the multisequential way in which hypermedia are experienced. They argue that, in hypertext, the traditional roles of author and reader as teller and listener become less clear. Hypertext readers, continually presented with chances to diverge and opportunities for supplementary information, must choose the narrative themselves. Footnotes, Endnotes, and the Experience of Reading Hypertext (<http://vpengl.wvu.edu/landow/reading.html>), which is itself a kind of online footnote to the journal *Victorian Poetry*, observes that the footnotes of scholarly articles perform a primitive version of the same function in an environment of paper and ink. They allow the reader to decide, mid-sentence, whether to leave the main text for more information or continue reading. In evolutionary terms, the footnote is an ancestor of the hypertext link. Perhaps it is now under threat from McManus's more flexible and better adapted hypertext.

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Hit parade

bmj.com

These articles scored the most hits on the *BMJ*'s website in the week of publication

JULY

- Papers: Bicyclist's vulva: observational study, plus Commentary: Attitudes to women's bicycling have changed**
2002;325:138-9
8153 hits
- Editorial: Daily doses of multivitamin tablets**
2002;325:173-4
6836 hits
- Editorial: Hormone replacement therapy**
2002;325:113-4
6370 hits
- Editorial: The world's most neglected diseases**
2002;325:176-7
5163 hits
- Education and Debate: Syphilis: old problem, new strategy**
2002;325:153-6
4946 hits
- Clinical Review: Chronic renal disease**
2002;325:85-90
4826 hits
- Editorial: Prevention of age related macular degeneration**
2002;325:1-2
4814 hits
- Primary Care: 10-minute consultation: Removal of ear wax**
2002;325:27
4405 hits
- Editorial: Primary prevention of coronary heart disease**
2002;325:56-7
4108 hits
- Editor's Choice: Can this be true?**
2002;325 (27 July)
4049 hits



AIDS: censoring the prevention message

Coverage of AIDS on South African soaps and chat shows has been dubbed "brilliant." The shortfall lies in its news and current affairs programmes

A proposal to introduce an HIV positive character into the US version of the children's television programme *Sesame Street* was ditched last month after the idea provoked uproar among Republican politicians. The show's producers were said to be interested in following the lead of the South African version of *Sesame Street*, which will introduce a character with the virus later this year in a new series to be shown on one of the state owned channels. Yet the kind of row that the proposal caused in the United States would have seemed strange in South Africa, where the idea was greeted with a yawn when it was announced in the country's largest circulating Sunday newspaper.

Sesame Street—a victim of the former South African regime's fear of all things foreign—was allowed on to the country's television screens only in the past couple of years. By then, South Africa had changed governments and its world view, dropped many of its old censorship laws, and developed one of the world's most severe AIDS epidemics. It had also developed a new style of censorship, which relies on the need to please the government—which doubts that HIV causes AIDS—or suffer the consequences. This has meant not being

able to set the political debate around AIDS and its origins in a proper context.

Judi Nwokedi, chief executive officer in charge of the South African Broadcasting Corporation's public broadcasting wing, says, "In theory, in South Africa there should not be a programme that does not deal with HIV," she says.

She believes that broadcasters, including her own, fall short of the mark. Her real worry, however, is that the shortfall is in news and current affairs, a worry shared by many journalists. "There is a contradiction in that the SABC is not able effectively to deal with the science and politics of the epidemic," she says, referring to the broadcasters' responses to the government's ambivalence around treatment issues. Outside of this, the programmes are "brilliant" she says. The contradiction she sees leads to a tussle between the "cognitive versus the emotional." While youngsters see and hear the right messages in soap operas and on chat shows, they will struggle with the urge to "listen to their comrades" in the political domain. The casualty of this, she says, is behaviour change. Most research tends to support her fears. Behaviour patterns have not changed.

Ms Nwokedi was previously attached to LoveLife, a non-governmental organisation that spends millions of rands annually in the media trying to get prevention messages across—largely to one audience, the one most at risk (young, black, and rural). LoveLife puts out rather frank messages on the largest radio station in the southern hemisphere (the SABC's Zulu speaking station). It deals with uncomfortable but widespread views such as the notion that young men who want sex are entitled to it. "I can take a woman whether she agrees or not" is the kind of phrase that often crops up on the show—in real life conversation. The station features popular disc jockeys in popular venues and deals with topics that most kids are confronted with but that parents are reluctant to face.

Parents, Ms Nwokedi says, are horrified when they are faced on this programme and similar ones with the regularity and frequency with which young kids have sex (HIV/AIDS in South Africa is reported in children well before the teens). And children repeatedly say that they wish they could hear sexual information from their parents first. This has spawned a large advertising campaign by LoveLife—in print media and on radio and television—with well-known personalities such as Nelson Mandela saying: "Love them enough to talk about sex."

This week, the independent television station eTV begins a series called *Beat It* (which is slang in South Africa for masturbation), put together by AIDS activists in the Treatment Action Campaign. The series is designed to explain to people what they can do if they find out they are HIV positive. It deals with ways of getting drug treatment, what the side effects are, and what the benefits are. Jack Lewis, one of those behind the series, believes treatment is the missing part that needs to be dealt with urgently. It is also the part the government and the state broadcaster, the SABC, have avoided most consciously.

However, eTV is a relatively small television company based in the Western Cape, which has an active treatment campaign running at its health clinics. There are few such independent television stations, and independent radio, a beneficiary of the 1994 elections and constitutions, will look to the bottom line before commissioning HIV/AIDS programmes. The only organisation likely to have been able or willing to deal with the needs of public health and the AIDS epidemic—and the notion of propagating a message—is the state broadcaster. And yet it is the SABC in particular that the government, with its eccentric view of HIV and AIDS, has sought to control, although not only to temper any possible outbursts of real AIDS reporting.

Until about a year ago, television journalists covering AIDS had to submit their videos to a senior staff member for vetting before broadcasting. And the SABC's former head of news and his deputy resigned within weeks of one another over a new round of effective censorship on topics the government of the day would rather see less independently broadcast. Many within the SABC fear that, while many straightforward references are made to sex and AIDS in most areas of broadcasting and print, the main HIV prevention message will continue to suffer.

It may be that the more conservative citizens of the United States who sought to keep the HIV positive character out of *Sesame Street* will have to stay away from the world summit on sustainable development in order to retain their particularly puritanical view of how to put AIDS messages across. But they were not due here for the summit in large numbers in any event.

Pat Sidley freelance journalist, Johannesburg, South Africa



Sesame Street (visited here by UN general secretary Kofi Annan); now the South African version of the show is to get an HIV positive Muppet

MARTY LEDERHANDLER/AP PHOTO

PERSONAL VIEW

Why can't I admit that I am unwell?

During the past four years I have worked as a full time doctor. I have completed a one year diploma course, trained in two new specialties, and presently have three different clinical roles. I have listened to and counselled many patients, worked with many colleagues, and have a reputation for being efficient, capable, and versatile. However, also during this time, unknown to anyone except my close family, I have had an extremely severe depressive illness.

I have made two serious attempts on my life, which have left me with permanent physical sequelae. I have fought off an attempt to section me under the Mental Health Act, and I have taken a battery of antidepressant/antipsychotic drugs that left me desperately tired and sick. Despite all this, I have remained at work.

There are several reasons for this. Firstly, I am and have been too ill to stop. I have a chronic suicidal pain condition, which has been linked with a type of post-traumatic stress syndrome. The main feature of this condition is an unremitting urge to end my life. It has been present in all my waking (and sometimes my sleeping) hours for the last four years. While attempting to maintain a relatively normal exterior, I have been battling with intrusive thoughts, imagery, and impulses to bring about my own extinction. At any moment when I am not occupied, I am at extreme risk of inflicting serious harm upon myself.

Secondly, I have stigmatised my own condition as it is a "mental illness." I have been, and am, too ashamed to tell my colleagues.

Lastly, and most significantly, I have always considered that it was my place in life to achieve. If I give in to what has happened to me, I will perceive that I have failed, and failure will be terminal for me.

I can only liken my existence during this time to a living agony, hell, nightmare, torture—in fact there are no words with which I can describe my life adequately. I have woken every day preoccupied with thoughts of killing myself and yet terrified that I might. I cannot do it. I have two growing children who wave goodbye to me every morning and expect to see me every night. It does not occur to them that while they are at school I might end my own life. I have been, and am, desperate, desolate, lost, lonely. Yet, every day I face friends, patients, and colleagues at work.

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email editor@bmj.com

How have I achieved this? I have managed by becoming a professional automaton. Every morning at work, I present the expected image and behaviours that I have learnt and depended on over the years, and that have become my professional identity. I have become very good at this. Outside this role I don't really know who I am.

There are several reasons why I needed to write this piece. Firstly, I need people—especially my colleagues—to know that I am suffering, but I cannot tell them because it is ingrained in me somewhere that doctors do not have these sorts of problems.

Secondly, I wonder how many doctors out there are also carrying on like me, battling from day to day with their problems. If there are many, I wonder why. What makes it so hard for us to admit that we are not well,

to admit that we should go a little easier on ourselves? Is it the training? Public expectation? Fear of condemnation from our colleagues? Or are we just driven people? As with most problems I suspect that it is a combination of

them all.

Thirdly, part of my need to write this is to thank the people who have devoted part of their lives to me. Although I have not been able to go public, I have been supported by a small group of people who have handled me with untiring care, concern, and understanding, and without whom I would not be here. One of these is my own general practitioner, whose empathy and support have been unwavering and who I have really needed to "be there." Another is my community psychiatric nurse, who has been solidly at my side through many a dark moment, and whose thoughts and ideas have sustained me from week to week. And yet another is my psychiatrist, who has arranged many an appointment at short notice. I also thank my husband and family, who have battled to understand me, and lastly my partner, who has loved me, talked to me, cried with me, and sat awake through many nights with me without complaint.

Writing this has not made me feel any better, as I hoped it would. But if anybody reading this is suffering as I am, then I hope it is a comfort to them to know that they are not alone. Maybe one day I will be able to give myself a break and admit to my colleagues and friends that I have a problem. I am working towards this.

My initial thoughts were to write this story in a dark, humorous way to ensure entertaining reading. But when I thought about it, I realised that it really wasn't funny.

I have managed by becoming a professional automaton

SOUNDINGS

On with the new

For a year we were without students, but a long curricular upheaval has worked its way through to the point at which our youngest colleagues are with us once more.

The fallow year was strange. Of course we missed them, but as busy doctors we found many other things to do in the time once devoted to their improvement. But they are among us again now, brightening up our lives.

They are young, gifted, and confident, their idealism a reproach to our world weariness, though an irreducible naivety remains: a comforting sign that the years have taught us much that is still not available even to the best educated students from the best of all medical schools.

But for once the term step change has some meaning. They are markedly different in specific ways. Their IT literacy is taken for granted. They are hooked up to a kind of web based educational placenta: a virtual medical school in parallel to the old physical one we knew. So they know when they log on each day what they will learn, where, and with whom, and even—to my mild astonishment—which bus will take them there.

They are inured to continuous systematic evaluation, and even happy with it. They turn out regular case reports that combine commendable human detail with thoughtful, referenced reviews of the relevant clinical topics. They have expectations of us and what they might learn from us, and even feel free to comment when asked in an exam about something not clearly flagged as core material in our module.

And they have us on the back foot. After four years of the new order, they are the experts while we are absolute beginners: survivors from a bygone age, striving under their clear eyed gaze to adapt to modern realities. In the circumstances, they are remarkably tolerant of our failings.

I wish them well. While a few of us might be tempted to interrogate them on the precise anatomy of the circle of Willis, or the once sacred intricacies of the brainstem, I am sure they would deal gracefully with any such archaic oneupmanship, knowing they could quickly learn the details if ever they needed to. But will they survive as house officers? We'll know quite soon. And will they make good doctors? Let's ask again in 20 years.

Colin Douglas *doctor and novelist, Edinburgh*